STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505406	A. BUILDING _____ B. WING _____	07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CARE CENTER	855 AARON DRIVE LYNDEN, WA 98264

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Quality Indicator Survey (QIS) conducted at Christian Health Care Center on 7/22/13, 7/23/13, 7/24/13, 7/25/13, and 7/26/13. A sample of 25 residents was selected from a census of 126. The sample included 23 current residents and the records of 5 former and/or discharged residents.

RECEIVED
AUG -9 2013
ADSA/RCS
Smokey Point

The survey was conducted by:

[redacted], R.N., BSN
[redacted], BSHS
[redacted], R.N., BSN
[redacted], R.N., BSN

The survey team is from:

Department of Social and Health Services
Aging and Long Term Support Administration
Residential Care Services, Region 3, Unit B
3906 172nd Street NE, Suite 100
Arlington, WA 98223

Telephone: (360) 651-6850
Fax: (360) 651-6940

Lynne Washke 7/30/13
Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

C. L Berb-El Bare Administrator 8/8/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505406	A. BUILDING _____ B. WING _____	07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CARE CENTER	855 AARON DRIVE LYNDEN, WA 98264

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow care plans for 1 of 2 residents (209). This failure resulted in the resident sustaining a non-injury fall. Findings include: Resident 209 was admitted to the facility on [redacted]/13, with diagnosis to include dementia and generalized weakness. The resident was not interviewable. The resident was assessed to be at risk for falls related to history of falls secondary to [redacted] and moderate [redacted]. The resident's plan of care dated 5/28/13, included "2 person assist for all transfers." Review of an occurrence report dated 7/2/13, documented a nursing assistant (NA 1) was attempting to transfer the resident from the bed to the wheelchair. The resident was no longer able to continue to stand, the NA assisted the resident to slide down to the floor. Resident 209's plan of care was not followed when the resident was transferred by one NA. Additionally, after the resident slid to the floor, the NA did not report the fall to the LN and instead	F 323	Resident 209 is now consistently transferred per Plan of Care. To protect residents in a similar situation, transfers for all residents whose Plan of Care directs two person (2PA) transfers have been monitored to assure Plan of Care compliance. To ensure that this problem does not recur, Staff NA1 is no longer employed by CHCC, all nursing staff has been in-serviced regarding Plan of Care compliance, and all NACs have been in-serviced regarding facility policy requiring LN assessment of residents after a fall. In addition, all new nursing department employees will be in-serviced regarding following Plan of Care for transfers and facility policy of informing the LN of a resident fall prior to moving the resident. To make sure that solutions are sustained, random observations of transfers by Team Leaders and Unit Coordinators will be completed on a regular basis. Results of observations will be reported at monthly Quality Assurance Meeting. DNS/Administrator is responsible to ensure correction.	9/1/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505406	A. BUILDING _____ B. WING _____	07/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN HEALTH CARE CENTER	855 AARON DRIVE LYNDEN, WA 98264

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2 moved the resident back into the bed without assessment for injury. When questioned, NA 1 readily admitted that she had transferred the resident by herself and was aware that the resident was to be transferred with the assistance of 2 staff. She further admitted to transferring the resident back into bed instead of calling for a nurse to assess the resident for injury. In an interview with the Administrator and Director of Nursing on 7/25/13, at approximately 2:30 p.m., they both agreed that the care plan and facility policy were not followed. They further stated, following the investigation of the incident. NA 1 was relieved from her position at the facility.	F 323		